



**MASSACHUSETTS**  
HEALTH POLICY COMMISSION

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# **NOTICE OF MATERIAL CHANGE FORM**

Health Policy Commission  
50 Milk Street, 8th Floor  
Boston, MA 02109

# NOTICE OF MATERIAL CHANGE

DATE OF NOTICE:

1. Name:

2.	Federal TAX ID #	MA DPH Facility ID #	NPI #
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## CONTACT INFORMATION

3. Business Address 1:

4. Business Address 2:

5. City: State: Zip Code:

6. Business Website:

7. Contact First Name: Contact Last Name:

8. Title:

9. Contact Phone: Extension:

10. Contact Email:

## DESCRIPTION OF ORGANIZATION

11. Briefly describe your organization.

## TYPE OF MATERIAL CHANGE

12. Check the box that most accurately describes the proposed Material Change involving a Provider or Provider Organization:

A Merger or affiliation with, or Acquisition of or by, a Carrier;

A Merger with or Acquisition of or by a Hospital or a hospital system;

Any other Acquisition, Merger, or affiliation (such as a Corporate Affiliation, Contracting Affiliation, or employment of Health Care Professionals) of, by, or with another Provider, Providers (such as multiple Health Care Professionals from the same Provider or Provider Organization), or Provider Organization that would result in an increase in annual Net Patient Service Revenue of the Provider or Provider Organization of ten million dollars or more, or in the Provider or Provider Organization having a near-majority of market share in a given service or region;

Any Clinical Affiliation between two or more Providers or Provider Organizations that each had annual Net Patient Service Revenue of \$25 million or more in the preceding fiscal year; provided that this shall not include a Clinical Affiliation solely for the purpose of collaborating on clinical trials or graduate medical education programs; and

Any formation of a partnership, joint venture, accountable care organization, parent corporation, management services organization, or other organization created for administering contracts with Carriers or third-party administrators or current or future contracting on behalf of one or more Providers or Provider Organizations.

13. What is the proposed effective date of the proposed Material Change?

## MATERIAL CHANGE NARRATIVE

14. *Briefly* describe the nature and objectives of the proposed Material Change, including any exchange of funds between the parties (such as any arrangement in which one party agrees to furnish the other party with a discount, rebate, or any other type of refund or remuneration in exchange for, or in any way related to, the provision of Health Care Services) and whether any changes in Health Care Services are anticipated in connection with the proposed Material Change:

15. *Briefly* describe the anticipated impact of the proposed Material Change, including but not limited to any anticipated impact on reimbursement rates, care referral patterns, access to needed services, and/or quality of care:

## DEVELOPMENT OF THE MATERIAL CHANGE

16. Describe any other Material Changes you anticipate making in the next 12 months:

17. Indicate the date and nature of any applications, forms, notices or other materials you have submitted regarding the proposed Material Change to any other state or federal agency:

## SUPPLEMENTAL MATERIALS

18. Submit the following materials, if applicable, under separate cover to [HPC-Notice@state.ma.us](mailto:HPC-Notice@state.ma.us).

The Health Policy Commission shall keep confidential all nonpublic information, as requested by the parties, in accordance with M.G.L. c. 6D, § 13(c), as amended by 2013 Mass. Acts, c. 38, § 20 (July 12, 2013).

- a. Copies of all current agreement(s) (with accompanying appendices and exhibits) governing the proposed Material Change (e.g., definitive agreements, affiliation agreements);
- b. A current organizational chart of your organization
- c. Any analytic support for your responses to Questions 14 and 15 above.

[Remainder of this page intentionally left blank]

This signed and notarized Affidavit of Truthfulness and Proper Submission is required for a complete submission.

**AFFIDAVIT OF TRUTHFULNESS AND PROPER SUBMISSION**

I, the undersigned, certify that:

1. I have read 958 CMR 7.00, Notices of Material Change and Cost and Market Impact Reviews.
2. I have read this Notice of Material Change and the information contained therein is accurate and true.
3. I have submitted the required copies of this Notice to the Health Policy Commission, the Office of the Attorney General, and the Center for Health Information and Analysis as required.

Signed on the 10 day of JAN, 2022, under the pains and penalties of perjury.

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

FORM MUST BE NOTARIZED IN THE SPACE PROVIDED BELOW:

  
\_\_\_\_\_  
Notary Signature

Copies of this application have been submitted electronically as follows:

Office of the Attorney General (1)

Center for Health Information and Analysis (1)

Notice of Material Change – Attachment

Sports Medicine North Orthopaedic Surgery, Inc.

Federal TAX ID # 04-3205435

2. NPI

- 1760423719
- 1699171470
- 1861837015
- 1376077552